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Notice of Independent Review Decision

Date notice sent to all parties:

September 17, 2012

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:
RECONSIDERATION: Deny 80 hours of chronic pain management program for the lumbar spine at Pain Recovery Clinic as requested by

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:
Board Certified Family Practice

REVIEW OUTCOME:
Upon independent review, the reviewer finds that the previous adverse determination/adverse determinations should be:

X Upheld (Agree)

Provide a description of the review outcome that clearly states whether medical necessity exists for each of the health care services in dispute.

INFORMATION PROVIDED TO THE IRO FOR REVIEW:
Cover sheet and working documents
Utilization review determination dated 02/27/12, 07/13/12, 08/17/12, 08/29/12
Prospective review response dated 09/03/12
Note dated 09/05/12
Request for reconsideration dated 08/23/12
Functional capacity evaluation dated 07/26/12
Behavioral evaluation report dated 08/02/12
Preauthorization request dated 08/13/12
Follow up evaluation dated 06/07/12
Physical therapy reassessment dated 07/13/12

PATIENT CLINICAL HISTORY [SUMMARY]:
The patient is a female whose date of injury is xx/xx/xx. On this date the patient slipped and fell. Treatment to date includes 12 sessions of physical therapy in

2010, epidural steroid injection x 3 in 2011, lumbar fusion in March 2012 and approximately 34 sessions of postoperative physical therapy. Functional capacity evaluation dated 07/26/12 indicates that current PDL is sedentary-light and required PDL is heavy. Behavioral evaluation report dated 08/02/12 indicates that BDI is 21 and BAI is 11. Diagnoses are pain disorder associated with both psychological factors and a general medical condition; and major depression moderate. Current medications are listed as Norco, Flexeril and Cymbalta.

Initial request for 80 hours of chronic pain management program was non-certified on 08/17/12 noting that the medical records submitted are largely inconsistent. The pre-op psychological screening in early 2012 indicated the patient was an appropriate candidate psychologically. The postoperative physical therapy and medical records indicate the patient was "doing well" with "good results" post op. We now have a functional capacity evaluation indicating the patient is functioning at a sedentary level and a behavioral evaluation demonstrating anxiety and depression and poor coping skills. Given the fact that the patient is now more than 2 years status post injury and the fact the medical records are largely inconsistent, the requested pain management program cannot be supported. The denial was upheld on appeal dated 08/29/12 noting that the medical records are inconsistent. The treating physician and physical therapy reports indicate that the patient is making good progress and good functional gains and has been progressing slowly toward the goals that have been set in physical therapy. There is no indication in the medical records that the claimant has ongoing chronic pain complaints and is not improving with the treatment that is being provided at this point. There has been no indication in the medical records provided for review that the claimant has excessive dependence on healthcare providers, spouse or family, has secondary physical deconditioning due to disuse or fear of avoidance and has any withdrawal from social activities or normal contact with others including work, reaction or other social contacts. There is no documentation provided that the claimant has continued uses of prescription pain medications other than the Cymbalta that is being used for the depressive affect that was documented of the claimant. There is no indication in the medical records provided for review that all diagnostic procedures necessary to rule out treatable pathology including imaging studies or invasive treatments have been completed prior to enrolling in this type of program.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS, AND CONCLUSIONS USED TO SUPPORT THE DECISION:

Based on the clinical information provided, the request for 80 hours of chronic pain management program for the lumbar spine at Pain Recovery Clinic is not recommended as medically necessary, and the two previous decisions are upheld. The submitted records fail to establish that the patient has exhausted lower levels of care and is an appropriate candidate for this tertiary level program. The patient has been diagnosed with major depression; however, there is no indication that the patient has undergone a course of individual psychotherapy to address this. As noted by the previous reviewers, the medical records are inconsistent. The treating physician and physical therapy reports indicate that the patient is making good progress and good functional gains and has been progressing slowly toward the goals that have been set in physical therapy. There is no indication in the

medical records that the claimant has ongoing chronic pain complaints and is not improving with the treatment that is being provided at this point. The Official Disability Guidelines do not recommend chronic pain management programs for patients who have been continuously disabled for greater than 24 months as there is conflicting evidence that these programs provide return to work beyond this period.

IRO REVIEWER REPORT TEMPLATE -WC

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:

X MEDICAL JUDGEMENT, CLINICAL EXPERIENCE, AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS

X ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES

ODG Pain Chapter

Criteria for the general use of multidisciplinary pain management programs:

Outpatient pain rehabilitation programs may be considered medically necessary in the following circumstances:

(1) The patient has a chronic pain syndrome, with evidence of loss of function that persists beyond three months and has evidence of three or more of the following: (a) Excessive dependence on health-care providers, spouse, or family; (b) Secondary physical deconditioning due to disuse and/or fear-avoidance of physical activity due to pain; (c) Withdrawal from social activities or normal contact with others, including work, recreation, or other social contacts; (d) Failure to restore preinjury function after a period of disability such that the physical capacity is insufficient to pursue work, family, or recreational needs; (e) Development of psychosocial sequelae that limits function or recovery after the initial incident, including anxiety, fear-avoidance, depression, sleep disorders, or nonorganic illness behaviors (with a reasonable probability to respond to treatment intervention); (f) The diagnosis is not primarily a personality disorder or psychological condition without a physical component; (g) There is evidence of continued use of prescription pain medications (particularly those that may result in tolerance, dependence or abuse) without evidence of improvement in pain or function.

(2) Previous methods of treating chronic pain have been unsuccessful and there is an absence of other options likely to result in significant clinical improvement.

(3) An adequate and thorough multidisciplinary evaluation has been made. This should include pertinent validated diagnostic testing that addresses the following: (a) A physical exam that rules out conditions that require treatment prior to initiating the program. All diagnostic procedures necessary to rule out treatable pathology, including imaging studies and invasive injections (used for diagnosis), should be completed prior to considering a patient a candidate for a program. The exception is diagnostic procedures that were repeatedly requested and not authorized. Although the primary emphasis is on the work-related injury, underlying non-work related pathology that contributes to pain and decreased function may need to be addressed and treated by a primary care physician prior to or coincident to starting treatment; (b) Evidence of a screening evaluation should be provided when addiction is present or strongly suspected; (c) Psychological testing using a validated instrument to identify pertinent areas that need to be addressed in the program (including but not limited to mood disorder, sleep disorder, relationship dysfunction, distorted beliefs about pain and disability, coping skills and/or locus of control regarding pain and medical care) or diagnoses that would better be addressed using other treatment should be performed; (d) An evaluation of social and vocational issues that require assessment.

(4) If a goal of treatment is to prevent or avoid controversial or optional surgery, a trial of 10 visits (80 hours) may be implemented to assess whether surgery may be avoided.

(5) If a primary reason for treatment in the program is addressing possible substance use issues, an evaluation with an addiction clinician may be indicated upon entering the program to establish the most appropriate treatment approach (pain program vs. substance dependence program). This must address evaluation of drug abuse or diversion (and prescribing drugs in a non-therapeutic manner). In

this particular case, once drug abuse or diversion issues are addressed, a 10-day trial may help to establish a diagnosis, and determine if the patient is not better suited for treatment in a substance dependence program. Addiction consultation can be incorporated into a pain program. If there is indication that substance dependence may be a problem, there should be evidence that the program has the capability to address this type of pathology prior to approval.

(6) Once the evaluation is completed, a treatment plan should be presented with specifics for treatment of identified problems, and outcomes that will be followed.

(7) There should be documentation that the patient has motivation to change, and is willing to change their medication regimen (including decreasing or actually weaning substances known for dependence). There should also be some documentation that the patient is aware that successful treatment may change compensation and/or other secondary gains. In questionable cases, an opportunity for a brief treatment trial may improve assessment of patient motivation and/or willingness to decrease habituating medications.

(8) Negative predictors of success (as outlined above) should be identified, and if present, the pre-program goals should indicate how these will be addressed.

(9) If a program is planned for a patient that has been continuously disabled for greater than 24 months, the outcomes for the necessity of use should be clearly identified, as there is conflicting evidence that chronic pain programs provide return-to-work beyond this period. These other desirable types of outcomes include decreasing post-treatment care including medications, injections and surgery. This cautionary statement should not preclude patients off work for over two years from being admitted to a multidisciplinary pain management program with demonstrated positive outcomes in this population.

(10) Treatment is not suggested for longer than 2 weeks without evidence of compliance and significant demonstrated efficacy as documented by subjective and objective gains. (Note: Patients may get worse before they get better. For example, objective gains may be moving joints that are stiff from lack of use, resulting in increased subjective pain.) However, it is also not suggested that a continuous course of treatment be interrupted at two weeks solely to document these gains, if there are preliminary indications that they are being made on a concurrent basis.

(11) Integrative summary reports that include treatment goals, compliance, progress assessment with objective measures and stage of treatment, must be made available upon request at least on a bi-weekly basis during the course of the treatment program.

(12) Total treatment duration should generally not exceed 20 full-day (160 hours) sessions (or the equivalent in part-day sessions if required by part-time work, transportation, childcare, or comorbidities). (Sanders, 2005) Treatment duration in excess of 160 hours requires a clear rationale for the specified extension and reasonable goals to be achieved. Longer durations require individualized care plans explaining why improvements cannot be achieved without an extension as well as evidence of documented improved outcomes from the facility (particularly in terms of the specific outcomes that are to be addressed).

(13) At the conclusion and subsequently, neither re-enrollment in repetition of the same or similar rehabilitation program (e.g. work hardening, work conditioning, out-patient medical rehabilitation) is medically warranted for the same condition or injury (with possible exception for a medically necessary organized detox program). Prior to entry into a program the evaluation should clearly indicate the necessity for the type of program required, and providers should determine upfront which program their patients would benefit more from. A chronic pain program should not be considered a “stepping stone” after less intensive programs, but prior participation in a work conditioning or work hardening program does not preclude an opportunity for entering a chronic pain program if otherwise indicated.

(14) Suggestions for treatment post-program should be well documented and provided to the referral physician. The patient may require time-limited, less intensive post-treatment with the program itself. Defined goals for these interventions and planned duration should be specified.

(15) Post-treatment medication management is particularly important. Patients that have been identified as having substance abuse issues generally require some sort of continued addiction follow-up to avoid relapse.